Case Example: REACH U.S. Charleston and Georgetown Diabetes Coalition: A Community-Academic Coalition for Decreasing Diabetes Disparities in African Americans

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Tell me about you and your profession—I am a……

A. Physician/ Health Care Provider
B. Behavioral therapist.
C. Administration
D. APRN
E. RN

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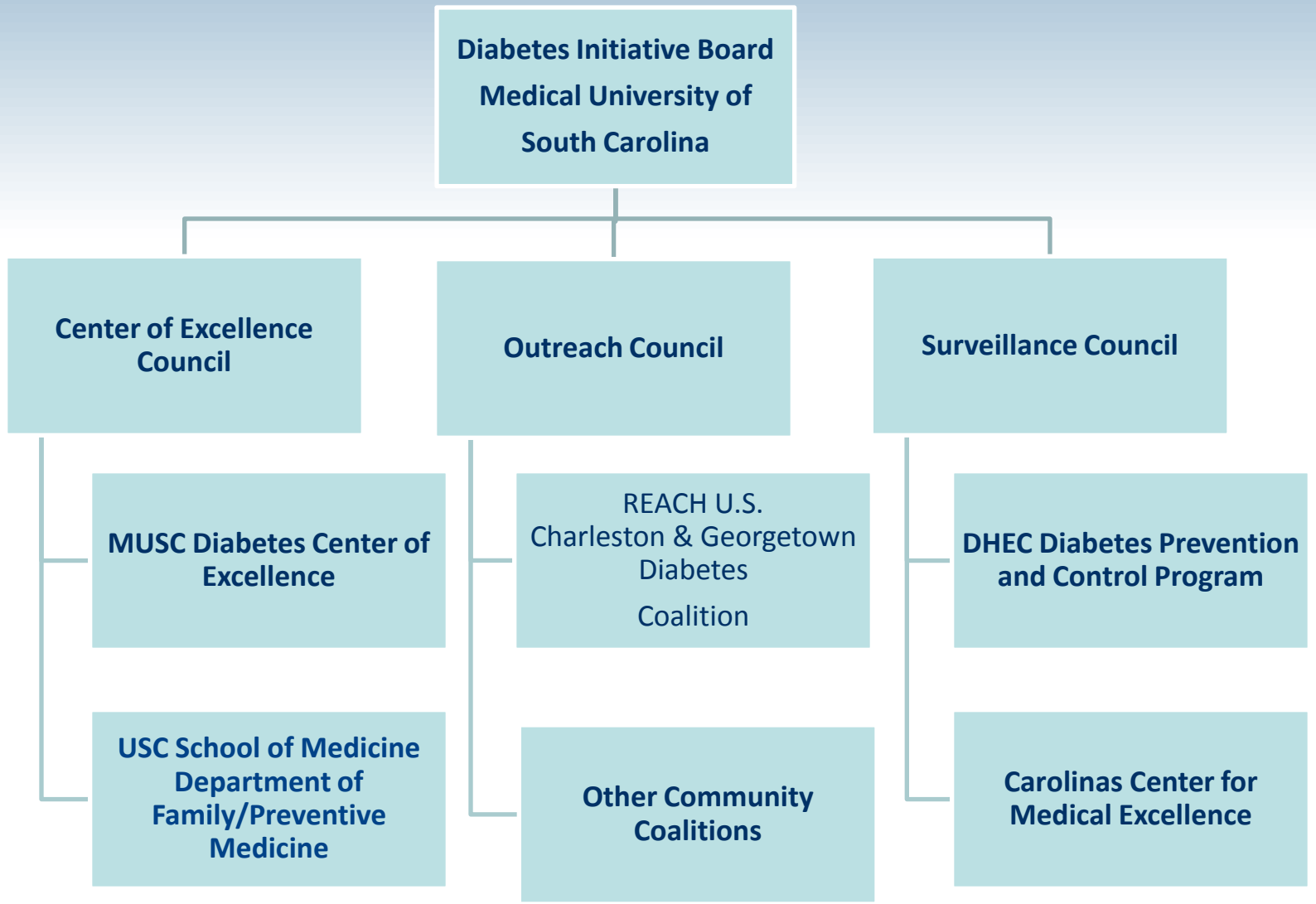

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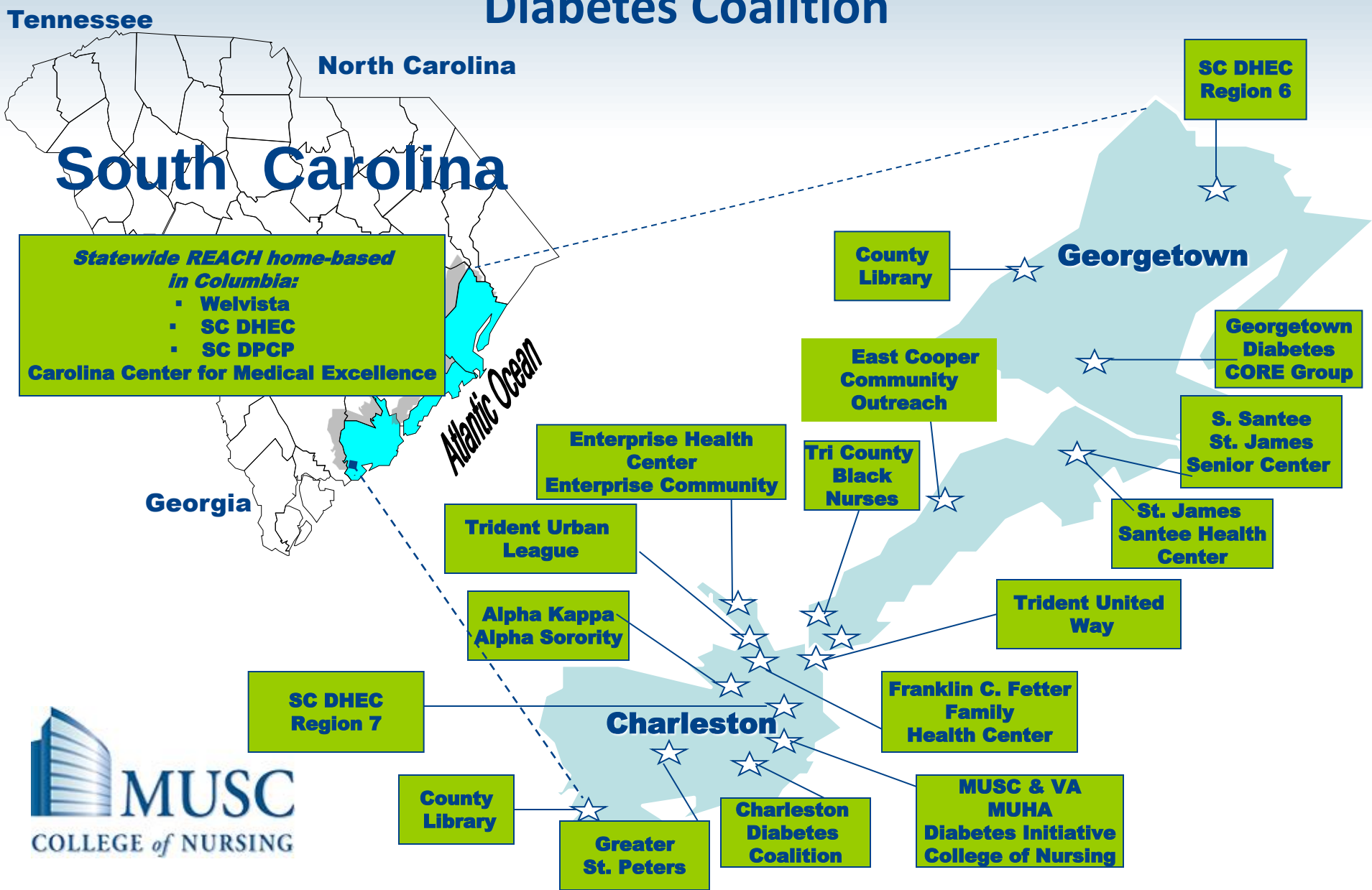
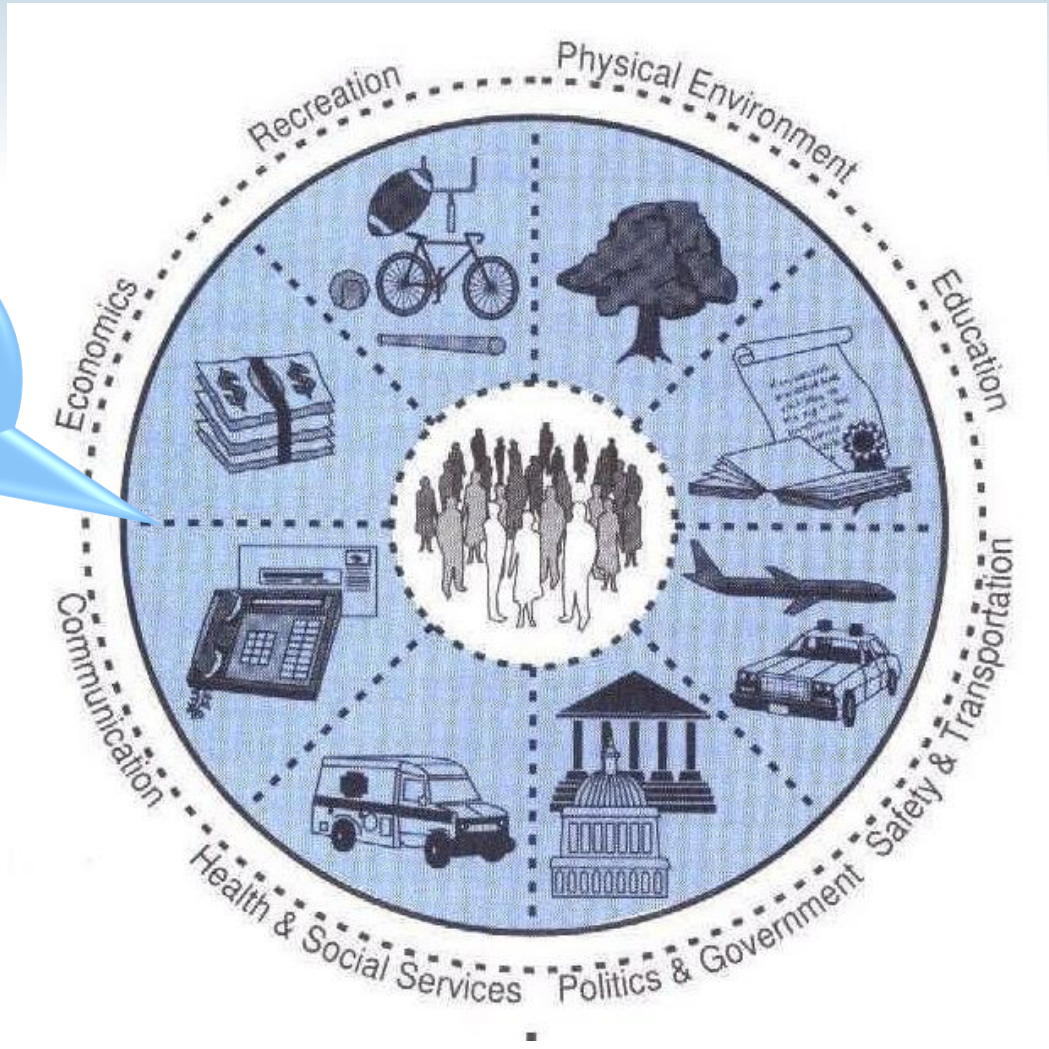
REACH: Charleston and Georgetown Diabetes Coalition



Our Community Systems Wheel

Faith Based



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E.T. Anderson and J.M. McFarlane (2006)

How many of the systems from previous slides are your working with?

- A. None
- B. 2-3
- C. More than 3
- D. All

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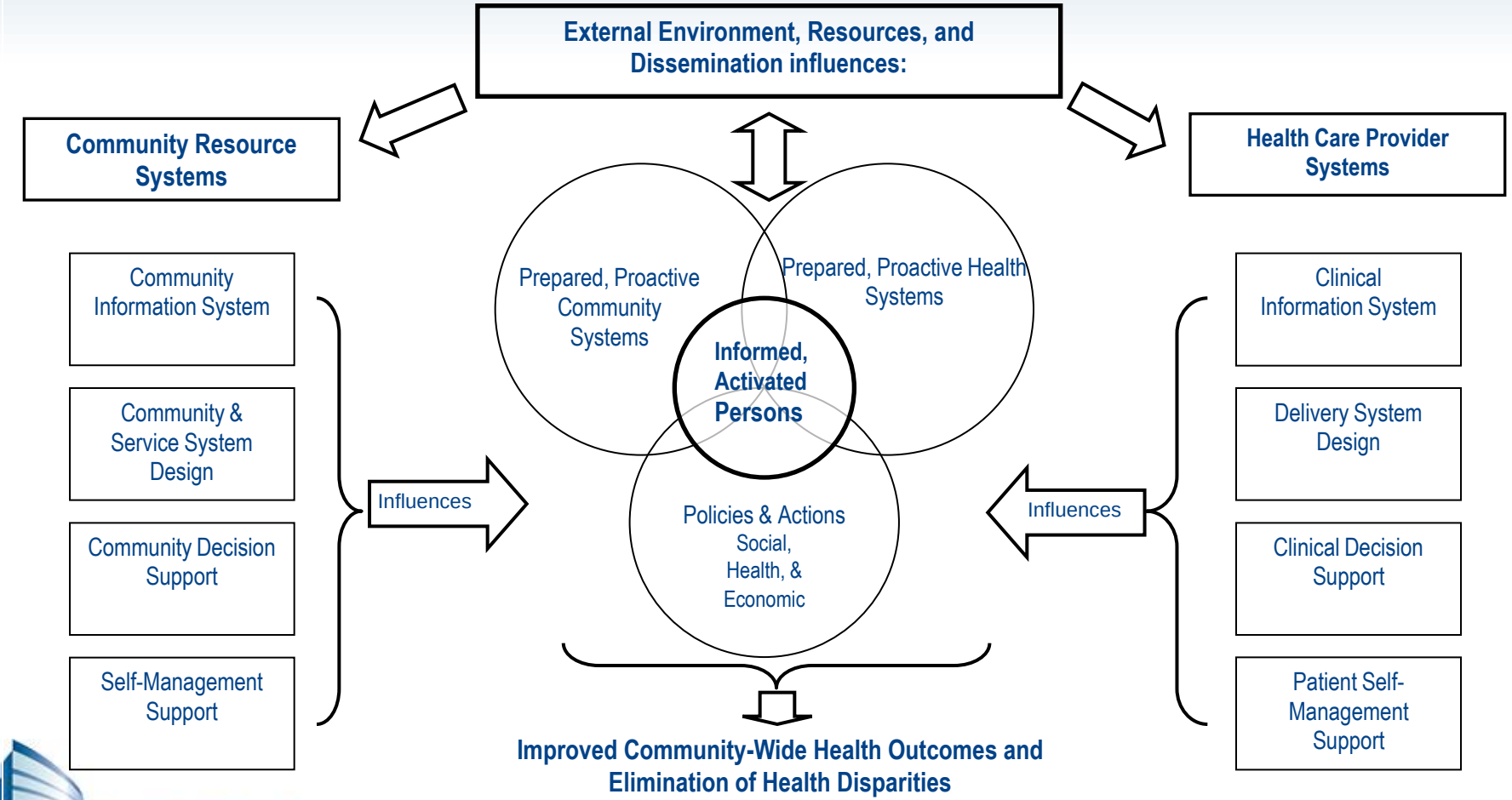
The Community Chronic Care Conceptual Model
REACH Charleston and Georgetown Diabetes Coalition



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(Jenkins, Pope, Magwood et al., PCHP 4 (1): 73)

Are you familiar with Chronic Care Model (Wagner)?

- A. Not at all
- B. I have seen it , but not used it
- C. I have used the model but am not clear about the component parts
- D. I am very familiar with the model

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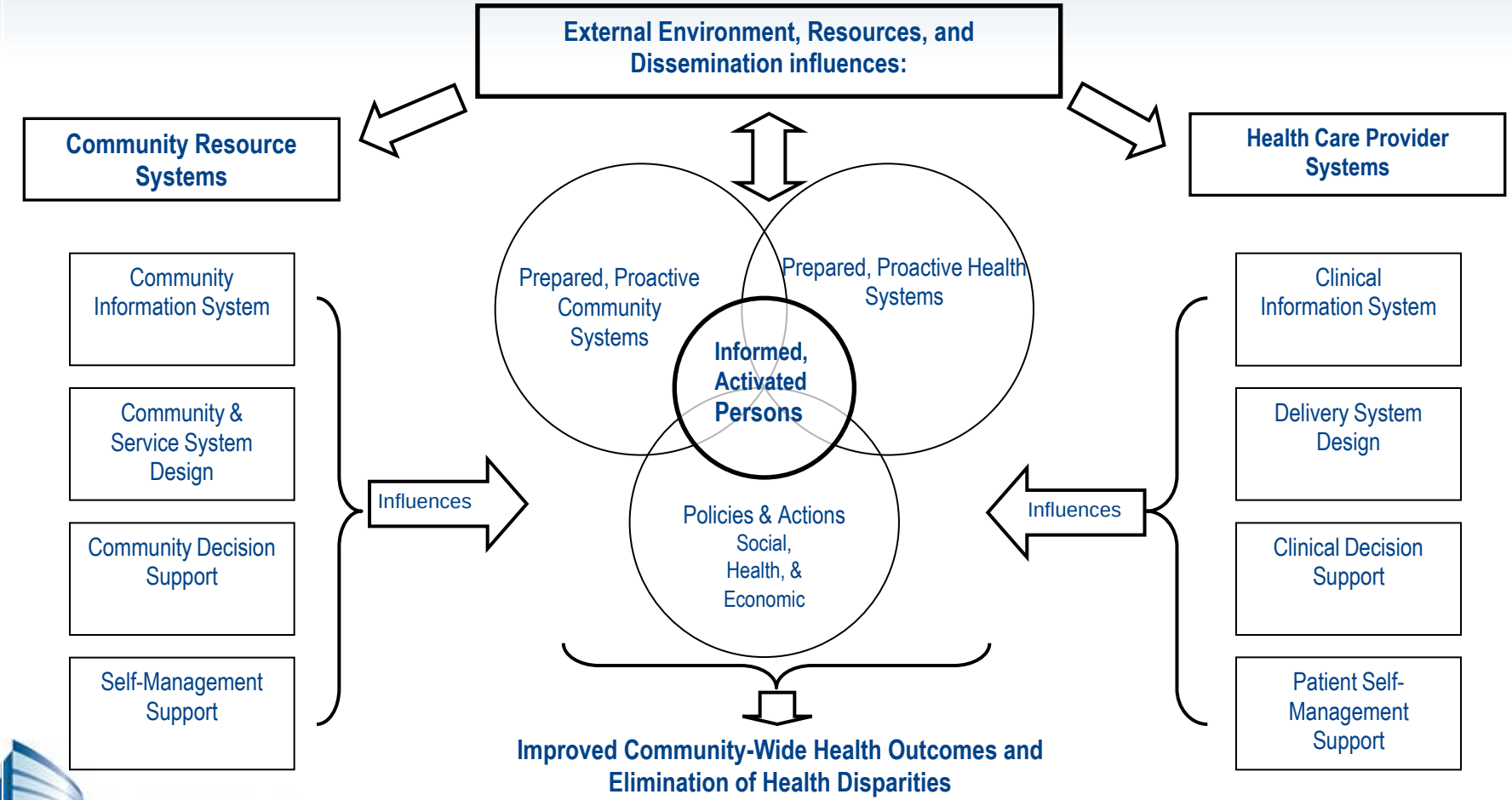
The Community Chronic Care Conceptual Model
REACH Charleston and Georgetown Diabetes Coalition



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(Jenkins, Pope, Magwood et al., PCHP 4 (1): 73)

REACH Coalition as Integrator

Partner-level functions

- Recruit Coalition members and build trust within African American community
- Establish partnerships with groups that exert community influence
- Train and conduct comprehensive assessment of needs, “upstream” contributor to diabetes disparities, assets for addressing disparities.
- Establish governance, bylaws, funding, and goals

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REACH Coalition as Integrator

Partner-level functions

- Enhance and strengthen community infrastructure and linkages (never replicate/compete)
- Select or develop/modify/test training materials
- Hire and train staff
  - Influential MD with diabetes expertise (consultant)
  - Community health workers (advocates/navigators)
  - Other—Administrative/financial management and data management/qualitative and quantitative evaluator(s)
- Add Coalition members and define contributions

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REACH Coalition as Integrator

Continuous learning and improvement

- Determine most efficient effective methods for capturing, analyzing, presenting, and tracking data over time to capture and track Coalition and staff activities, for improving care at individual, systems, community and county levels
- Verify/compare data with other sources
- Recognize successes quickly and look at systems for sustainability

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REACH Coalition as Integrator

Continuous learning and improvement

- Evaluate and refine communication and feedback systems across multiple sectors with particular focus on those who can change or influence processes/outcomes
- Share succinct summaries with government and political decision-makers
- Share first with those most affected—particular community data—as members have stories to tell

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REACH Coalition as Integrator

System-level functions

- Identify policy and practice changes for improving diabetes within and across systems—statewide guidelines and laws.
- Assess barriers/facilitators for policy changes, and developing processes to address barriers across multiple sectors-health systems, communities, families and individuals
- Translate/incorporate new research findings
- Scalability to other communities---Legacy Projects

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REACH Coalition as Integrator

System-level functions—Sustainability

- Financial sustainability—specifically what $ are needed, how to generate, what needs sustaining
- REACH Coalition has Coalition in each county) that became 501(c)3 organizations that maintain community outreach and DSC provides “scientific expertise” while communities provide “community expertise” to DSC
- Leverage: Local funders, pooling resources, incorporate other health issues

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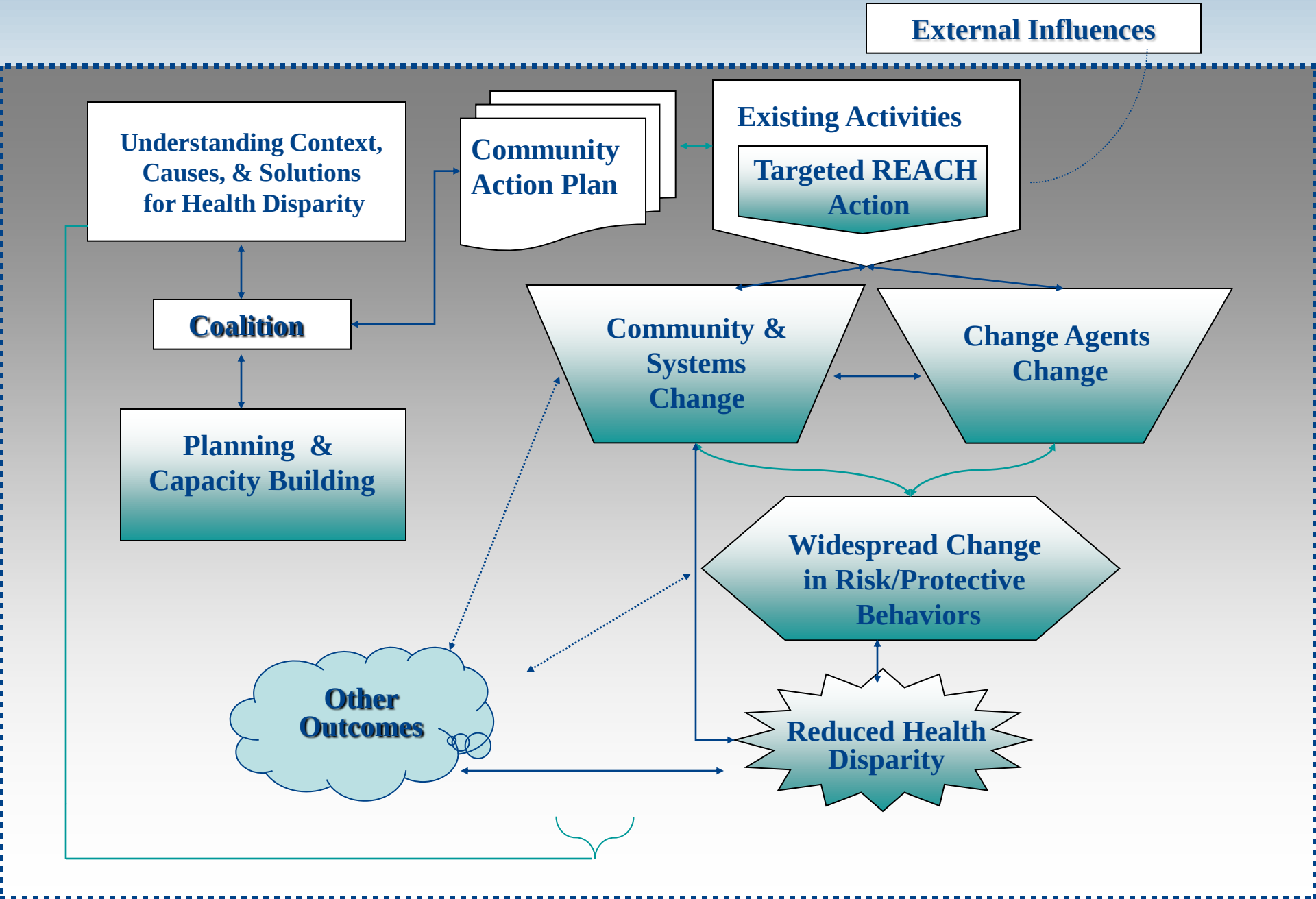
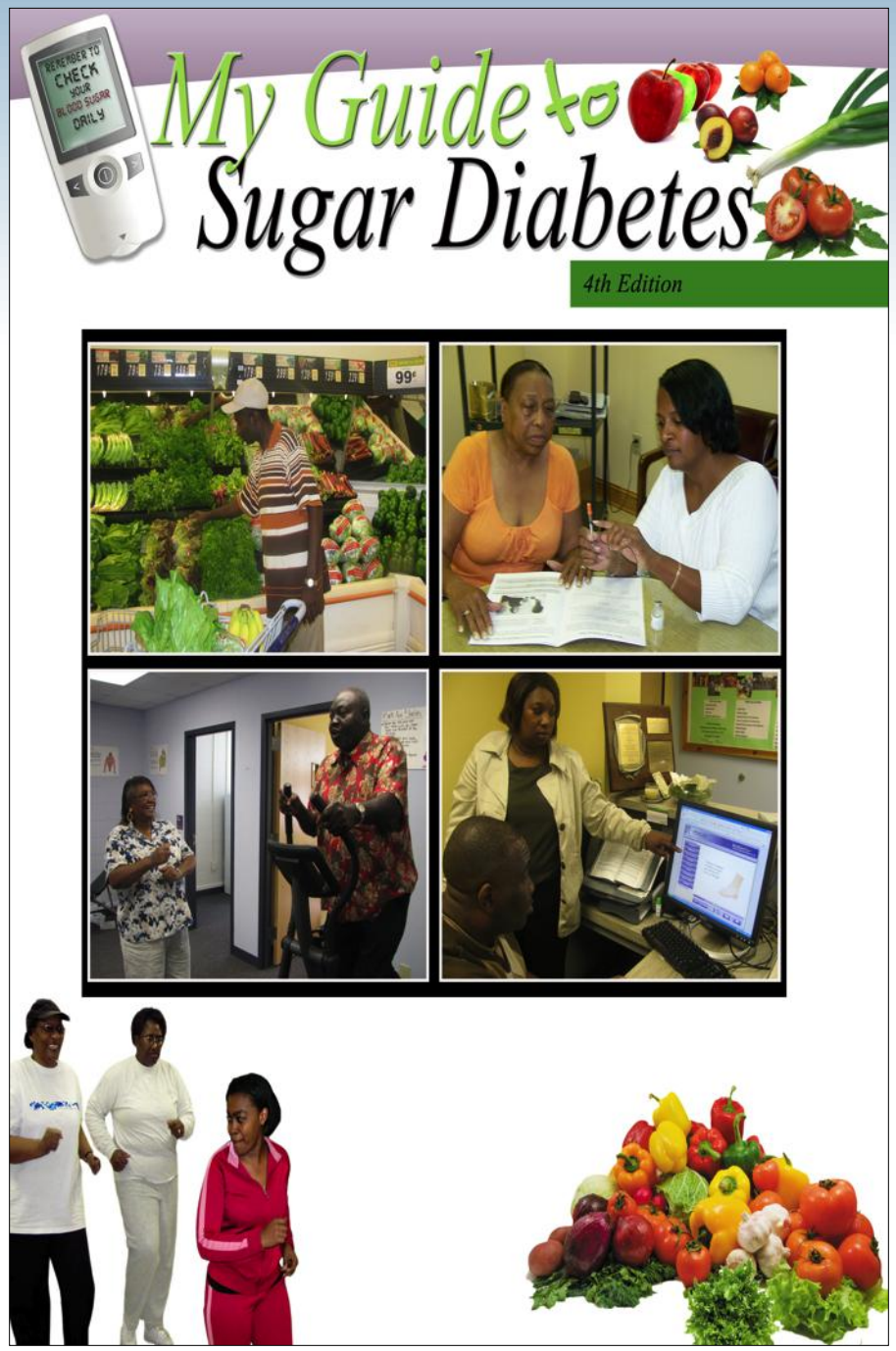
Evaluation Logic Model

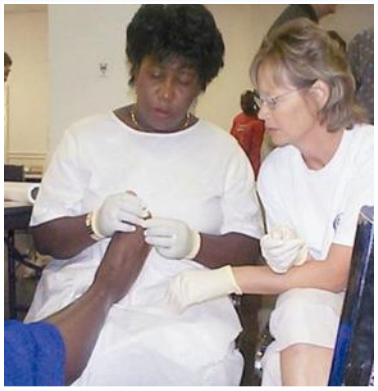




Working effectively with communities moves the science from Bench to Bedside to Countryside more rapidly.

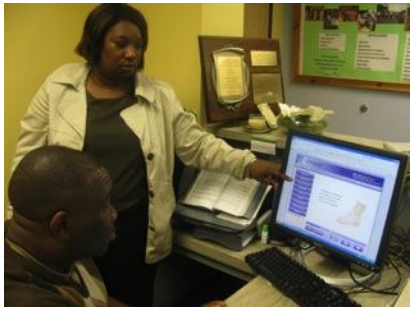
Community and Media Activities reached >125,000 African Americans

Neighborhood Walk and Talk Groups



Skill-Building for CHAs and Volunteers

Community Screening and Education



Individual/ Group Education

≥ 3 sessions = 3.2% drop in A1c

Photos used with permission of clients and partners

Georgetown County Diabetes Core Activities

Physical Activity

Walk-A-Thon

Health Screenings

Educational Classes

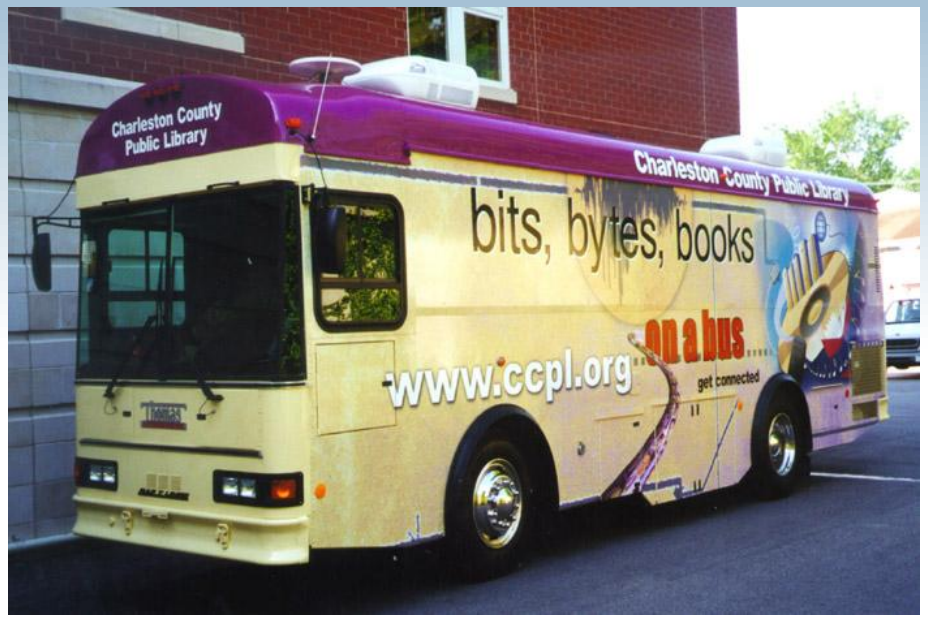
Healthy Cooking

Gardening Class

Dinner Theater

Gardening

REACH at the Library



Cybermobile

Equipped with 6 Internet laptop

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Diabetes at the Library

X-Plain.com
Patient Education Institute

MedlinePlus®
National Library of Medicine

Diabetes Introduction | Credits | Terms of Use

- Introduction
- What is Diabetes?
- Signs & Symptoms
- Treatment Options
- Controlling Diabetes
- Hyperglycemia
- Complications
- Summary

Diabetes is a disease that affects millions of Americans every year.

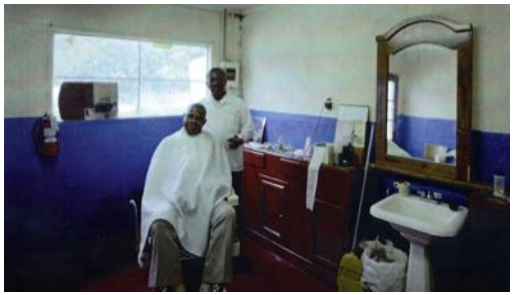
Slide 1 of 108

Quit | Comments | VOLUME − + 0% 100% | Repeat Page

You are online (proxy: none). C

Recognition and Rewards

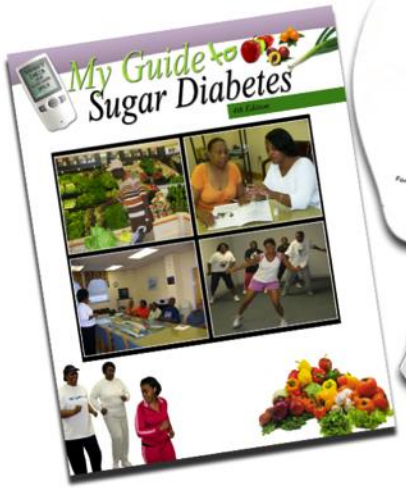
Womanless Wedding



Men's Talk

Talk about Diabetes & Foot Care

Media



PRINTED MATERIAL

GARAGE BANNER

BUS PLACARDS

FLYERS

% Change in Diabetes Care for African Americans

	2000	2007	2012
• A1C Testing	76.8	97.1	
• Blood Pressure <130/80	24	38	
• Lipid Testing	47.3	87.2	
• Eye Exam	34	76	
• Feet Exam	64	97.3	
• Kidney Tests	13.4	56	

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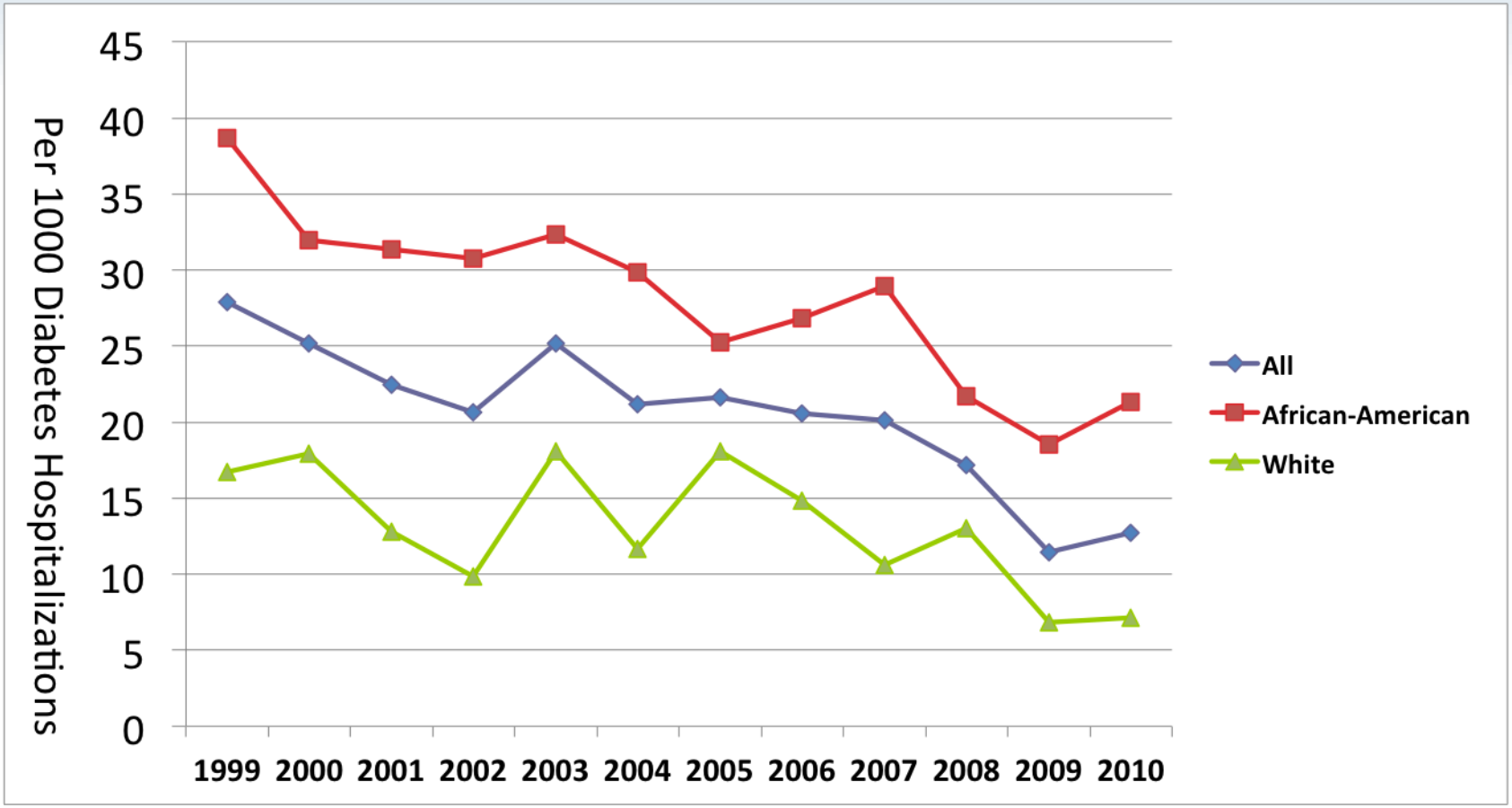
Charleston and Georgetown Counties LEA Rate per 1000 DM Hospitalizations



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Data Source: SC Hospital Discharge Data, Office of Research and Statistics

Prepared by SCDHEC Office of Epidemiology and Evaluation updated 03/12

Preliminary Estimated Outcomes for Reduction in Diabetes LEAs in African Americans in 2 Counties

- Improved QOL for person whose legs were saved.
- Cost savings:
  - Costs per amputation in Georgetown County = $54,736 in 2008
  - Costs per amputation in Charleston County = $42,783 in 2008
  - Reduction in amputations compared to 1999 = 44% in African Americans
  - Cost savings of > $2 million/year.

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Note: release for photo

Questions?

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Other than behavioral problems, what is the major cause of disability and death?

A. Poor health care
B. Environmental exposure
C. Social circumstances
D. Genetic predisposition

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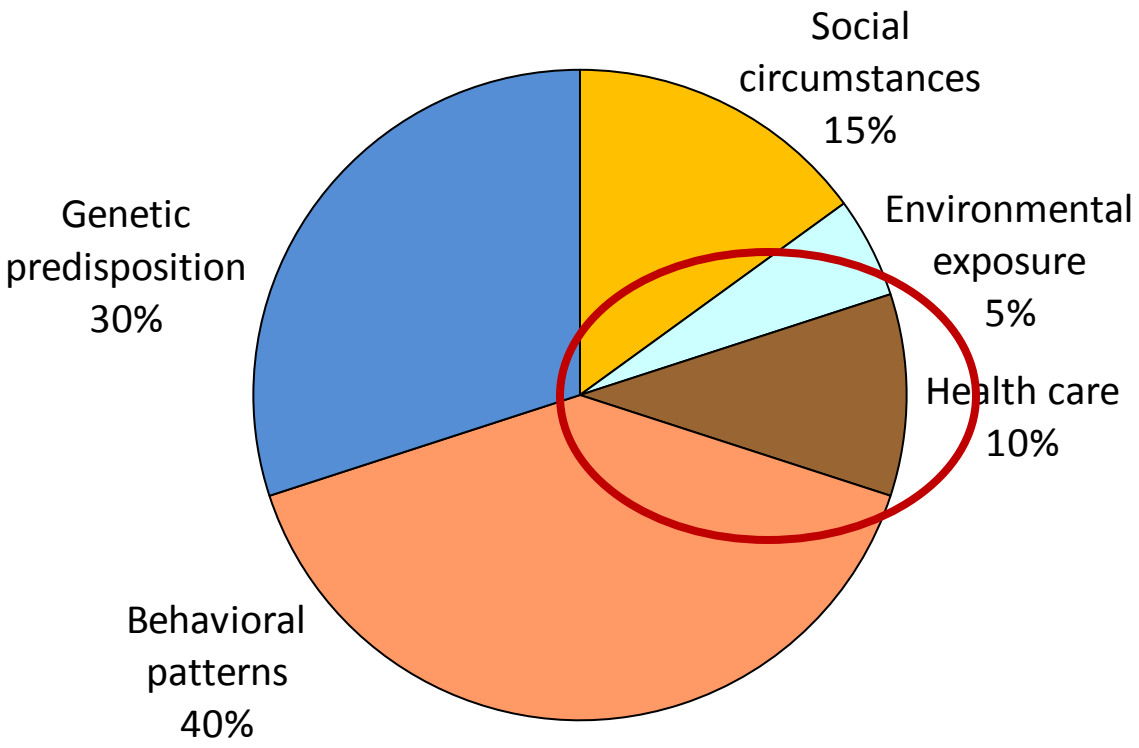
Determinants of Health and Their Contribution to Premature Death

Proportional Contribution to Premature Death



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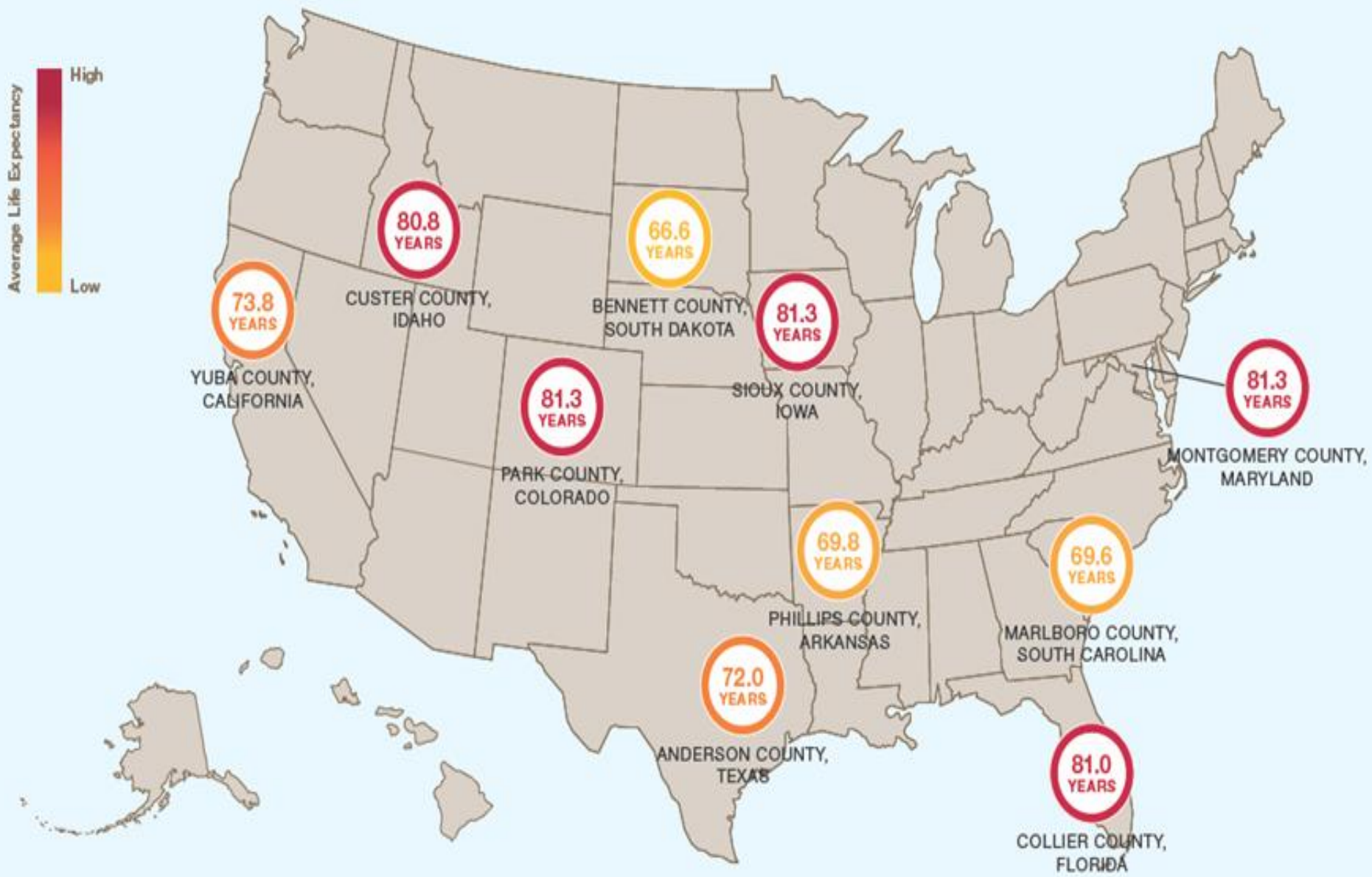
Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93.

Across America, Differences in How Long and How Well We Live



Within States, Large Gaps in Life Expectancy

States	Highest Life Expectancy	Lowest Life Expectancy	Difference in Life Expectancy
Alabama	76.8	71.7	5.1
Alaska	76.9*	76.9*	N/A
Arizona	80.9	73.9	7.0
Arkansas	78.0	69.8	8.2
California	80.8	73.8	7.0
Colorado	81.3	74.8	6.5
Connecticut	79.2	76.8	2.4
Delaware	76.5	75.8	0.7
District of Columbia	72.0	72.0	N/A
Florida	81.0	70.2	10.8
Georgia	78.9	72.2	6.7
Hawaii	80.5	77.3	3.2
Idaho	80.8	74.9	5.9
Illinois	79.6	74.3	5.3
Indiana	79.1	73.5	5.6
Iowa	81.3	76.1	5.2
Kansas	80.3	73.2	7.1
Kentucky	77.4	72.0	5.4
Louisiana	76.7	71.6	5.1
Maine	78.8	75.6	3.2
Maryland	81.3	68.6	12.7
Massachusetts	79.5	76.5	3.0
Michigan	80.2	73.4	6.8
Minnesota	81.1	76.2	4.9
Mississippi	76.1	70.1	6.0
Missouri	79.3	70.8	8.5

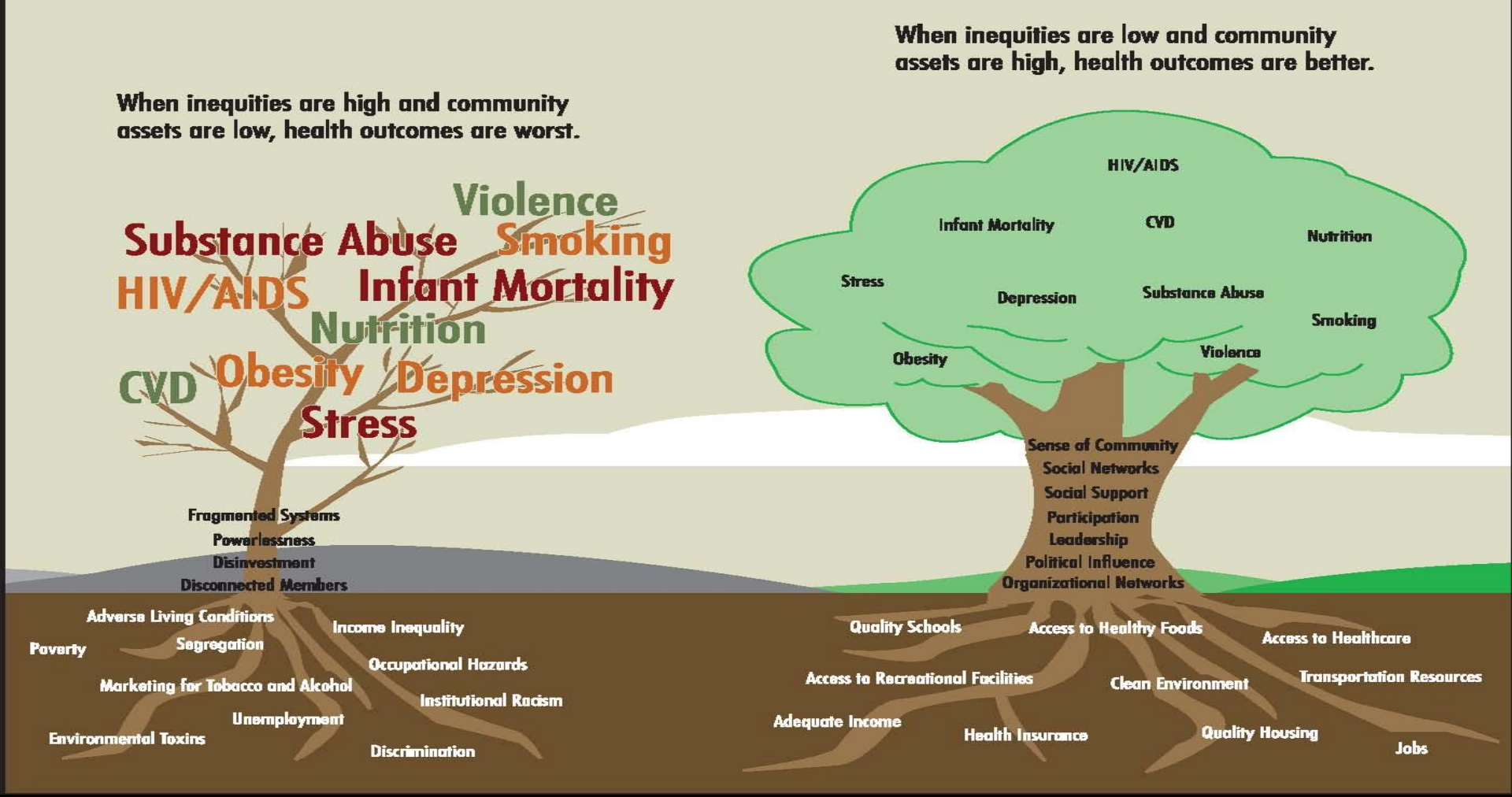
States	Highest Life Expectancy	Lowest Life Expectancy	Difference in Life Expectancy
Montana	79.3	72.8	6.5
Nebraska	80.1	76.4	3.7
Nevada	79.8	74.5	5.3
New Hampshire	78.7	76.2	2.5
New Jersey	79.9	74.7	5.2
New Mexico	79.6	74.2	5.4
New York	79.5	75.0	4.5
North Carolina	78.6	71.2	7.4
North Dakota	80.0	76.3	3.7
Ohio	79.7	73.4	6.3
Oklahoma	77.9	72.0	5.9
Oregon	80.9	75.5	5.4
Pennsylvania	79.4	72.3	7.1
Rhode Island	79.5	77.5	2.0
South Carolina	78.9	69.6	9.3
South Dakota	80.3	66.6	13.7
Tennessee	78.8	72.4	6.4
Texas	80.2	72.0	8.2
Utah	80.8	76.3	4.5
Vermont	79.0	76.9	2.1
Virginia	80.9	69.6	11.3
Washington	80.3	74.9	5.4
West Virginia	77.2	70.4	6.8
Wisconsin	80.1	75.7	4.4
Wyoming	78.2	73.9	4.3

*Due to multiple changes in county/census divisions, life expectancy for Alaska was estimated as a single figure, assigned to all counties in the state.

Source: Murray CJ, Kulkarni SC, Michaud C, et al. "Eight Americas: Investigating Mortality Disparities Across Races, Counties, and Race-Counties in the United States." Public Library of Science, 3(9): e260, 2006.

Growing Communities: Social Determinants, Behavior and Health

Our environments cultivate our communities and our communities nurture our health.



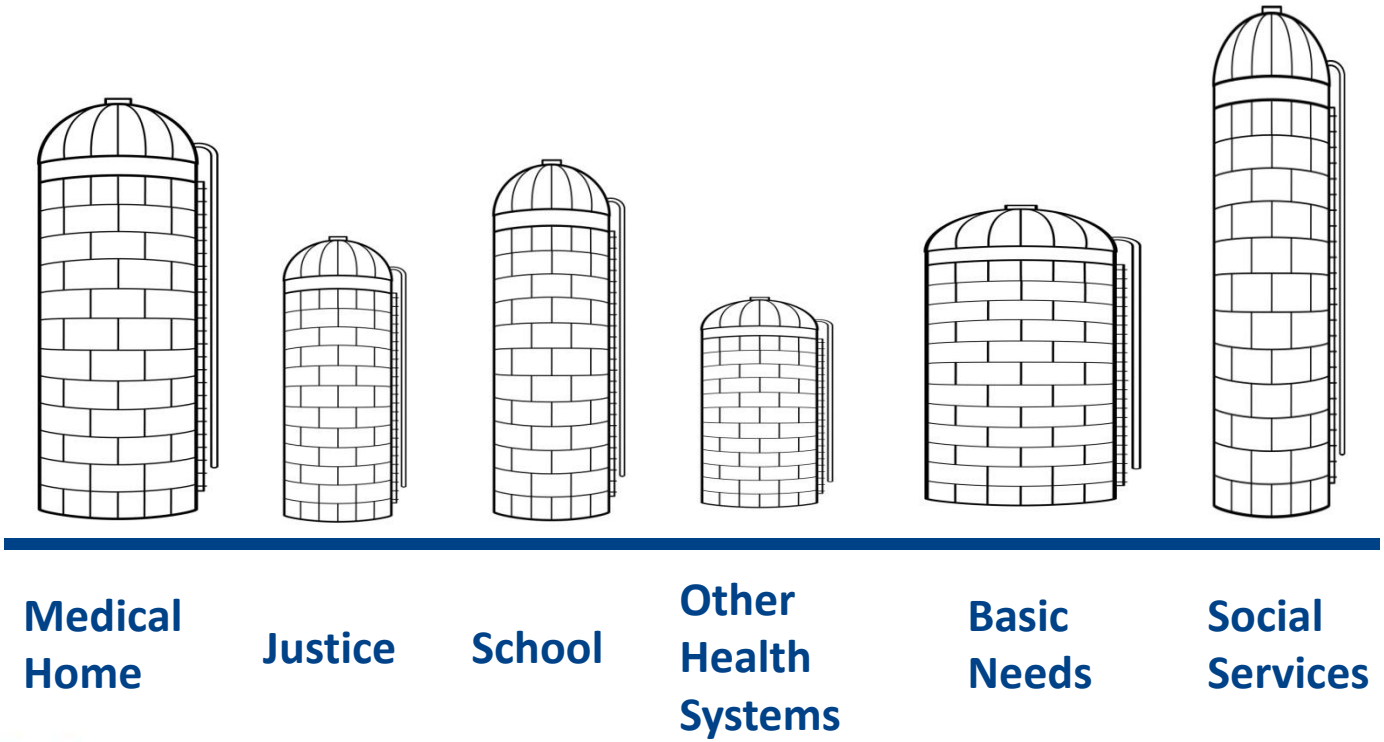
SAFER • HEALTHIER • PEOPLE™

CDC™

As a Care Coordinator

Our Role is to Connect the Silos and Build Healthy Communities

Connect the Silos



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What Next?

1. Identify high risk, high cost users and high prevalence, moderate cost users to identify strategies to improve quality of care and population health outcomes and costs of care.
2. Improve care coordination, promote prevention and reduce unnecessary utilization.
   - Person Centered Health Home with Navigator
   - Transdisciplinary team-based care
   - All providers operating at the "top of their license" and assisted through community change

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3. Improve the health of population, via:
   - Measurable shared health outcomes for a geographic population, not just patients served
   - Coalition of multi-sector partners
   - Systems and organizational changes
     - Integrator to implement system level change
     - Shared learning process (QI collaborative) for change
   - Social marketing/health education campaigns
   - Training and technical assistance
4. Integrate and share data across multiple systems
5. Implement payment reforms for promoting health and disease prevention.

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What might we do?

- Bring together health systems and providers, public health departments, multi-sector community-based partners, families and payers---No one model fits all, but make sure “vulnerable” at table.
- These consortia would demonstrate the potential to:
  - Rapidly design, develop and implement community change.
  - Contribute to the evidence base for population-based prevention.
- Participation in a collaborative learning process to facilitate sharing of best practices, testing out new ideas, including data for change, and shared problem solving.
- A design, innovation, technical assistance and support center would be charged with facilitating the collaborative learning, innovation and improvement efforts across all sites.

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The Evolving Health Care System

The First Era (Yesterday)

- Focused on acute and infectious disease
- **Germ Theory**
- Short time frames
- Medical Care
- Insurance-based financing
- **Reducing Deaths**

Health System 1.0

The Second Era (Today)

- **Increasing focus on chronic disease**
- **Multiple Risk Factors**
- **Longer time frames**
- **Chronic Disease Mgmt & Prevention**
- **Pre-paid benefits**
- **Prolonging Disability free Life**

Health System 2.0

The Third Era (Tomorrow)

- **Increasing focus on achieving optimal health**
- **Complex Systems - Life Course Pathways**
- **Lifespan/ generational**
- **Investing in population-based prevention**
- **Producing Optimal Health for All**

Health System 3.0

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“Everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing and medical care.”

Universal Declaration of Human Rights 1948

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Acknowledgements

This project is funded by the REACH Charleston and Georgetown Diabetes Coalition CDC Grant/Cooperative Agreements U50/CCU422184 and 1U58DP001015 from the Centers for Disease Control and Prevention.

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The contents are solely the responsibility of the author and community partners and do not necessarily reflect the official views of the funding agencies.

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Thank you to all community residents with diabetes, community leaders, and our partners who have worked to eliminate diabetes disparities:

- Charleston Diabetes Coalition
- AKA Sorority (N. Charleston)
- Greater St. Peter's Church
- Diabetes Initiative of SC
- East Cooper Community Outreach
- Franklin C. Fetter Family Health Centers
- MUSC College of Medicine
- MUSC College of Nursing
- Georgetown Diabetes CORE Group
- MUSC Library
- SC DHEC Diabetes Prevention and Control Program and Epidemiology
- SC DHEC Region 7 and 8
- St James-Santee Family Health Center
- Tri-County Black Nurses Association
- Trident United Way 211 Help Line
- Trident Urban League

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